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International healthcare worker migration in Asia Pacific: International policy responses

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Abstract: *The growth of the international migration of health workers in recent decades has taken place in the context of the transnationalisation of healthcare provision as well as of governance and policy responses. This paper examines international policy responses to cross-border health worker migration in the Asia Pacific region. These include multilateral (global and regional) and bilateral policy agreements, policy dialogue and programmes of action in relation to key issues of ethical recruitment, ‘circular’ migration and labour rights and key themes of health workforce planning and management. The paper brings original new analysis of international datasets and secondary data to bear on the pressing and important questions of what international policy initiatives and responses are at work in the Asia Pacific region, and what these mean for the nature of migration governance in the region. The paper’s focus routes the evidence and argument towards current research and policy debates about the relationship between health worker migration, health worker shortages and poor health outcomes. In this, the paper brings new insights into the analysis of the international policy ‘universe’ through its emphasis on multiple and intersecting cross-border institutions, initiatives and actors operating across different scales. Coherent national and international strategies for integrated health worker migration governance and policy need to incorporate these insights, and the paper considers their implications for current strategies to attain universal health care and improved health outcomes in Asia Pacific and beyond.*

Keywords: *Asia Pacific, governance, health workforce, migration, public policy, transnationalisation*

Introduction

The growth of the international migration of health workers in recent decades has taken place in the context of the transnationalisation of healthcare involving various actors and institutions at national, regional and global levels. Global governance and policy on health worker migration is evolving to reflect these dynamics (OECD, 2010; World Health Organization (WHO), 2010; World Health Organisation/Organization for Economic Cooperation and Development (WHO/OECD) 2010; Yeates and Pillinger, 2013; Makulec, 2014; Commission on Health Employment and Economic Growth, 2016). This paper examines these international policy responses to cross-border health worker migration within the Asia Pacific region.¹ It brings

original analysis of international data on multilateral and bilateral policy initiatives and responses in the Asia Pacific region and considers what these mean for migration governance in the region. The paper demonstrates the critical importance of effective integrated health worker migration governance in attaining universal healthcare and improved health outcomes in the Asia Pacific, and discusses how a focus on transnational policy can help with that.

The paper’s focus on the Asia Pacific responds to the fact that much of the burgeoning literature on international health worker migration is from the perspective of the ‘crisis’ faced by developed countries with shortages of health workers (North America, Western Europe and Australia) largely at the expense of middle- and low-income countries. There is a dearth of literature focused on the *regional* contexts and dynamics of such migration, which obscures migration occurring among developing countries, intra-regionally and on a ‘South–South’ basis

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(Hujo and Piper, 2010). Our focus on the Asia Pacific enables an examination of such regional dynamics relating to differing levels of development, health, social and economic inequalities between (and within) countries, varied regimes of healthcare governance and resourcing, and divergent healthcare outcomes. By incorporating the array of international actors, institutions and responses in relation to the Asia Pacific, this paper contributes fresh evidence from an instantiated regional context of international policy responses to health worker migration. In addition, it demonstrates the value of an expanded analytical framework for understanding the governance and policy 'universe' in relation to the intersections of health workforces, migration and development (including health outcomes).

The paper is organised as follows. The next section, Asia Pacific health workforces, provides brief contextual analysis of health worker migration, health resourcing and health outcomes across Asia Pacific. The following two sections present an original analysis of data on international policy responses to health worker migration of multilateral agreements (Multilateral institutions, actors and policies) and bilateral agreements (Bilateral labour agreements). The final section (Discussion and Conclusions), relates the evidence presented in this paper to the question of how a focus on transnational policy and governance can help with attaining universal healthcare and improved health outcomes in the Asia Pacific.

Asia Pacific health workforces: Contexts

The Asia Pacific region is characterised by divergence and inequality. Besides including countries and economies of highly disparate levels of wealth, there are also substantial differences in income and human development, health systems and levels of health resourcing (OECD/WHO, 2016). Health workers, the focus of this paper, are a central element of health resourcing and the cornerstone of health systems in the Asia Pacific, as elsewhere. The size, skill-mix, competency, geographic distribution and productivity of the health workforce are factors determining access to high-quality health services (Campbell *et al.*, 2013; OECD/WHO, 2016: 62).

Three contextual factors are relevant to the Asia Pacific region. First, the size of the health workforce and health spending vary across the region (OECD/WHO, 2016: 63). There are striking disparities between the richest countries in the region (Australia, Japan, Korea, New Zealand and Singapore) and the poorest ones (Bangladesh, Cambodia, India, Nepal and Vietnam). For example, Australia has 17 times more doctors per 1000 of its population than Nepal, and 23 times more nurses, and its total health spending per capita (USD PPP) is 50 times that of Bangladesh (OECD/WHO, 2016: 63). Second, health spending is a critical determinant of adequate health workforce-to-population ratios (Campbell *et al.*, 2013). Illustratively, Bangladesh, Cambodia, India and Indonesia have government health spending accounting for less than one-third of total health spending and low worker–population density ratios (Campbell *et al.*, 2013; WHO Global Health Observatory, 2017). Third, countries that invest higher levels of healthcare resourcing capable of sustaining higher worker–population density ratios and higher skilled birth attendance coverage enjoy superior health outcomes. For example, maternal mortality ratios tend to be lower in Asia Pacific countries where government health spending (per capita and/or as a proportion of total health expenditure) is higher. In Bangladesh, Lao, Timor-Leste and Papua New Guinea high maternal mortality ratios are associated with low worker–population density and low health expenditure (WHO Global Health Observatory, 2017).

The region has consistently featured in WHO analyses of critical shortages of health workers over the last decade. The region contains 12 countries that do not meet the international (WHO) thresholds for workforce density² (WHO, 2006). Of these countries, half of them fall significantly short on the measure of 80% coverage of a skilled birth attendant (doctor, nurse or midwife) (Bangladesh, Bhutan, Lao, Myanmar, Papua New Guinea and Timor-Leste). Although the region contained 'only' 6 of the 157 countries identified as having critical shortages, South-East Asia accounted for three-quarters of all health-care worker shortages globally. As the WHO noted, '[i]n absolute terms, the greatest shortage [of health workers] occurs in South-East Asia, dominated by the needs of Bangladesh, India and Indonesia' (WHO, 2006: 12). The combined population of these three countries alone is 1.73

billion people, about one quarter of the world's population (UNDESA, 2017).

WHO's *Global strategy on human resources for health: workforce 2030* (WHO, 2016) forecasts a growing demand for healthcare workers, amounting to some 40 million additional healthcare jobs by 2030. This sits alongside continuing shortages in 2013 and projected to 2030, as defined in the Sustainable Development Goals index of 4.5 physicians, nurses and midwives per 1000 population. Globally needs-based shortages of healthcare workers in countries currently below the index is estimated at 17.4 million in 2013 and projected at 14 million in 2030. Again, the biggest shortages in absolute terms are in South-East Asia (6.9 million in 2013 and 4.7 million in 2030), while the most severe challenges remain in the African region. This data does not take into account the higher burden of disease in South-East Asia compared to other parts of the world.

International health worker migration is important in this context because it impacts upon the overall availability of skilled health workers and health outcomes. In the Asia Pacific, such migration reflects intra-regional inequalities in power, income and wealth. For example, Australia and New Zealand are the major health worker importing states in the region, while the Philippines, India and Indonesia are the main exporting ones. New Zealand and Australia draw on health labour from poorer countries within the Asia Pacific as well as from outside it (Australia, for example, draws on sub-Saharan Africa, especially South Africa and Zimbabwe) (Pillinger, 2012; Negin *et al.*, 2013). Singapore and Taiwan are also regionally important destination countries for health workers from the Philippines, while Indonesia is the only other country besides the Philippines to be allowed to dispatch nurses to Japan (Yeates, 2009; Pillinger, 2013). A significant health migration corridor out of the Asia Pacific region involves the Philippines, Bangladesh and Indonesia to the Middle East, especially the Gulf states, which in turn often serve as transit countries to the UK, Ireland, USA and Canada (Sarfati, 2003; Adokli, 2006; Yeates, 2009; Connell, 2010).

International health worker migration, along with difficulties in attracting and retaining health workers, are among several factors impacting upon the quality of healthcare and the health

worker workforce (Campbell *et al.*, 2013; WHO, 2016). Other factors include the rate at which health workers enter into and complete training, labour force participation, retirement, outflow to other sectors, migration from rural to urban areas, unemployment and full-time/part-time work. At the same time, 'shortages' of health workers can co-exist with a substantial pool of skilled medical and nursing labour not practising their professions.³ Export-oriented health workforce strategies and cultural expectations favouring medical or nurse training as a route to emigration can mitigate efforts to increase aggregate supply in the health workforce.⁴ The relationship between health worker migration and health worker shortages is far from straightforward. Several of the countries in the remit of this paper would have a 'shortage' of nurses even if all those who were being trained stayed in nurse employment in their home countries. In Bangladesh, for example, aggregate nurse production is a key factor in its shortages, as it does not train sufficient nurses per capita. In the Philippines, aggregate production is adequate but many nurses train with the expectation of migrating and a sizeable proportion of trained nurses do not practice their profession.⁵

Multilateral institutions, actors and policies

Just as there is no single international organisation regulating migration, so there is no overarching global migration governance framework on health worker migration. The International Labour Organization (ILO), WHO, World Bank (WB) and International Organization on Migration (IOM) discuss health worker migration as part of their broader remit and have introduced measures and initiatives to build capacity and promote inter-state cooperation in this area. The principal multilateral frameworks governing international health worker migration governance in the Asia Pacific are the Association for Southeast Asian Nations (ASEAN) and the WHO Global Code of Practice on the International Recruitment of Health Personnel (hereafter the WHO Global Code). The former approaches international health migration as a trade in services issue, while the latter approaches it as an issue of workforce planning and sustainability.

ASEAN is a regional trade and security bloc for countries in Southeast Asia. One of its pillars, the ASEAN Economic Community, promotes intra-regional 'free' trade (including services) among its 10 member states. Skilled migration of health workers (and other professionals) and the cross-border trade in health services are seen as vital parts of successful regional cooperation (Arunanondchai and Fink 2006; Kanithasen *et al.*, 2011; Kittrakulrat *et al.*, 2014). To this end, three Mutual Recognition Agreements (MRAs) enable improved mobility of health professionals within a regional health services labour market (ASEAN, 2017). They permit designated health professionals⁶ to practice in another ASEAN country without the further requirement to pass other market-access assessments (e.g. fitness to practice) prior to being registered to practice there (Kittrakulrat *et al.*, 2014). The ASEAN MRAs enable mutual recognition of medical, nursing and dental practitioners. Like the European Union (EU), ASEAN seeks to regionalise regimes of cooperation and harmonisation relating to qualifications and does not put limits on the numbers of health workers permitted to migrate to other ASEAN states (save for immigration regimes), and there is no 'social clause' that conveys a duty on the part of signatory states to balance the right to migrate with the right to healthcare. ASEAN departs from the EU approach in that its MRAs promote circular and temporary migration, whereas EU citizens are entitled to free movement of labour.

The international harmonisation of the regional right to practice in ASEAN member states is impeded by institutional diversity such as stringent registration procedures, including a local language requirement (Thailand) and a citizenship requirement (Indonesia, the Philippines) (Manning and Sidorenko, 2007). There is significant divergence between the different regimes governing health professionals, though ASEAN member states at least have unified national regimes.⁷ Mostly, each country decides the requirements for health professionals to practice (Kittrakulrat *et al.*, 2014). For MRAs to work optimally, medical education, qualification, training and professional practice systems need to be harmonised (Arunanondchai and Fink 2006). In practice, the creation of a fully functioning regional labour market for health professionals remains a long-

term prospect. The dearth of data among ASEAN health labour forces prevents comprehensive monitoring of health worker migration or of the MRAs as they function in practice.

In the early 2000s, as developments in ASEAN to regionalise health service labour markets were unfolding, there was a parallel and growing momentum to institute a more socially responsible approach to the international regulation of health worker migration. The publication of the Global Health Report (WHO, 2006) marked a call to action to resolve the health worker crisis and urged states to develop ethical policies to take account of the implications of recruitment from 'developing' countries, particularly those which experience large shortfalls of health workers. If the Global Health Report marked a turning point in awareness of the need for better global cooperation and coordination, its call to action arose from prior international action and collaboration. Examples include the former Health Worker Migration Initiative and Global Health Worker Alliance (GHWA), both allied to the WHO. For instance, the joint initiative of the WHO and GHWA, the Kampala Declaration and Agenda for Action (WHO/GHWA, 2008), was launched under the banner of 'Health workers for all and all for health workers', while WHO programmes incorporated 'horizontal' support for the health workforce as part of efforts to strengthen health systems. For example, the Global Strategy for Women's and Children's Health was the result of a multilateral consultation sponsored by WHO and United States Agency for International Development (USAID) in 2005, leading to the development of a global technical framework to address the global health worker crisis (Poz *et al.*, 2006). Otherwise, joint OECD/WHO work in building data and indicators of health worker migration in source and destination countries and the WHO Global Code (see below) also helped to shift thinking about the need for multilateral responses in this area and for countries of destination to engage more systematically in health planning and forecasting of their future training and staffing needs.

Other international organisations were similarly present and active. The ILO approached the matter as a migrant workers' rights protection issue, linked to its normative standards on labour migration. It has sponsored sector-wide and

social dialogue approaches, including the ILO *Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers* (2010–2014), which was funded by the EU to address skilled health worker migration from a source country perspective (Philippines, India and Vietnam) and with the aim to improve the governance of circular migration of skilled healthcare workers through a multi-stakeholder approach (Yeates and Pillinger, 2013). Diaspora engagement formed a key plinth of IOM approaches to health worker migration, linked to harnessing ‘social remittances’ for ‘development’ by supporting the transfer of knowledge, skills and technology and diaspora capacity building to benefit source countries. The WB has invoked the potential value of international services trade agreements as an instrument to regulate health worker migration (Yeates and Pillinger, 2013). All of these international responses understand health worker migration as a global issue, although country-based technical assistance, project assistance or consultative forums are the most common initiatives in practice. Otherwise, these multilateral organisations have collaborated through multilateral partnerships, the most important of which is the WHO Global Code (discussed below).

More recently in 2016, on foot of the 2030 Agenda for Sustainable Development and in meeting the targets set out in the Sustainable Development Goals, the UN Secretary General established a global health worker platform led by a joint initiative among the WHO, OECD and ILO, which resulted in the establishment of the UN High-Level Commission on Health Employment and Economic Growth, with an agenda to develop ‘... ambitious solutions to ensure that the world has the right number of jobs for health workers with the right skills and in the right places to deliver universal health coverage’ (Commission on Health Employment and Economic Growth, 2016: 6). One of the objectives is to ‘...intensify support for national, regional and international investments and intersectoral reforms’ (Commission on Health Employment and Economic Growth, 2016: 6). This renewed effort seeks to address the projected shortfall of 18 million health workers, mainly in low- and lower-middle income countries, by 2030. Core to this is to expand, transform and create a sustainable health workforce, and to create 40 million new jobs in health and social care aimed at

strengthening health and social protection systems, good governance and building economic growth (linked to investments in health services and in the health workforce) (High-Level Commission on Health Employment and Economic Growth, 2016). These issues will be taken forward in the WHO, OECD and ILO platform jointly tasked with addressing health worker shortages. Connected to this is the implementation of the WHO *Global strategy on human resources for health: workforce 2030* (WHO, 2016), adding extra impetus to the urgency of addressing projected shortfalls of health workers in the context of the goal of universal healthcare.

It is in this context that the WHO Global Code (WHO, 2010) merits particular attention. The WHO Global Code aims to promote dialogue on, and good practice in, international recruitment of health workers, encouraging countries to achieve greater sustainability, while recognising the importance of ethical recruitment and the basic human right of every person to migrate. It is a voluntary agreement and neither the WHO nor any other organisation has powers to enforce it beyond the exertion of moral leverage. It reflects a ‘call for action’ for governments, other national stakeholders and multilateral organisations to collaborate around good practice approaches to health worker migration. The Code has helped to raised awareness of the issues needing to be addressed urgently on a national and international scale (Siyam *et al.*, 2013; Sumption and Fix, 2014). Some, however, doubt the effectiveness of a voluntary code (Tankwanchi *et al.*, 2014; Bourgeault *et al.*, 2016). Bourgeault *et al.*'s (2016) research on source and destination country perspectives found a general low level of awareness about the Code, with many destination countries having limited awareness that ratios of population to health workers health in source countries fell well below the WHO's critical thresholds. Bourgeault *et al.* argue that: ‘Simply put: the Code does not have prominence in those countries that need it most, namely those still lacking sufficient health workers and experiencing outgoing out-migration of those they train’ (2016: 122).

The 2015 review of the WHO Global Code found an increase in the numbers of countries reporting on the implementation of the Code, and argued that it was gaining legitimacy, and remained relevant. However, the review called

for better implementation and capacity building at global, regional and country level support for effective implementation of the Code (WHO, 2015). The Commission on Health Employment and Economic Growth (2016) also notes that many countries with critical health workforce shortages continue to need support in implementing the Code and notes that: 'These instruments could be made more effective by an updated broader international agreement on the health workforce, including provisions to maximize mutuality of benefit from socially responsible health worker migration' (2016: 48).

Yeates and Pillinger (2013) found that the WHO Global Code variously provided opportunities to institute further initiatives, be it to initiate research programmes or to extend engagement with states on issues of health worker governance, management and planning. Importantly, the Code makes it clear that the onus lay on all countries, irrespective of their development status. This is important given that many countries are at once countries of origin and destination and that countries spanning the entire development range experience health worker shortages (Campbell *et al.*, 2013, Table 1: 20; WHO, 2006). Nevertheless, the onus clearly lies with protecting low(er) income countries given that they account for the overwhelming majority of those with health worker shortages. This is of relevance to the Asia Pacific in general and Southeast Asia in particular given that, as discussed earlier, in absolute terms it has the greatest shortfall of health workers in the world. Developed countries bear particular responsibility to protect health resources and the health of their populations by ceasing to recruit health workers from these countries with shortfalls of health workers. The symbolic power of the Code is therefore significant given that several high-income countries have become, and are set to remain, dependent on foreign health workers to avoid shortfalls of qualified health workers occurring in their own territories.⁸

However, the overall lack of progress in strengthening the global institutional framework governing health worker migration is a reflection of the unwillingness of destination country governments to engage in binding measures, as seen in the growth of multilateral non-binding initiatives and consultative forums, and continued enthusiasm for trade-based responses to

health worker shortages and labour market 'liberalisation' measures (notably the promotion of temporary and circular migration) (Wickramasekara, 2008; Yeates and Pillinger, 2013). In their own ways, ASEAN and the WHO Global Code both epitomise the reluctance to engage in transnational institution-building and regulation that surpasses what is minimally necessary to address some of the direct social consequences of labour market and services trade liberalisation. Crucially, neither of them challenge the growth of temporary and circular migration.

Bilateral labour agreements

Most international agreements governing the international migration of health workers are agreed on a bilateral basis, usually between two participating governments. Bilateral labour agreements (BLAs) are specifically tailored to those countries' circumstances. However, there are significant variations in terms of the content and quality of agreements, their emphasis on protecting labour rights, and of the implementation of the BLAs in practice (Dhillon *et al.*, 2010; Yeates and Pillinger, 2013; Makulec, 2014; Plotnikova, 2014). BLAs have been promoted by the ILO, OECD and WHO as important mechanisms for workforce planning, managing workforce migration and guaranteeing fundamental rights at work. The WHO Code also recommends that BLAs can mitigate some of the negative impacts of migration by specifying key labour rights and ethical recruitment processes, as well as referencing ILO standards on fundamental rights at work and migration (including the ILO Migration for Employment Recommendation No.86 which set out a framework for protecting migrants' rights in government BLAs). In the context of the EU, for example, mobility partnerships have been a mechanism not only for addressing health workforce shortages in EU countries, but also for promoting comprehensive measures for cooperation, transparency and ethical recruitment (Dhillon *et al.*, 2010; Makulec, 2014).

In principle, BLAs can also be an important mechanism to protect migrant workers' rights to decent work standards and social protection and this in turn can mitigate the negative

Table 1. Summary overview of international agreements and arrangements on skilled health worker migration of National Reporting Instrument (NRI)-returning Asia Pacific countries

WHO Regional Office	Country	International agreement or arrangement	Type of international measure	Partner country/countries, and date (where given), and occupations covered
South-East Asia Regional Office (SEARO)	Bangladesh	YES	Bilateral	Middle Eastern Countries
	Bhutan	YES	Bilateral	Cuba, Myanmar, India, Nepal, 2 years (no start or end date given) – doctors
	Indonesia	YES	Bilateral	Japan (2008) – nurses; Timor-Leste (2010–2012) – midwives
	Maldives	YES	Bilateral	Sri Lanka (2014–2018), Bangladesh (2014–2018) – doctors, nurses, nurses/midwives, dentists, other paramedical
	Myanmar	YES	Bilateral	Bhutan (2003–2004), Brunei (2003–2004) – doctors
	Thailand	NO	NA	NA
Western Pacific Regional Office (WPRO)	Australia	NO	NA	NA
	Cambodia	YES	Bilateral	Brunei Darussalam (2015) – doctors, nurses, dentists
	Cook Islands	NO	NA	NA
	Japan	NO	NA	NA
	Kiribati	NO	NA	NA
	Lao	NO	NA	NA
	Malaysia	YES	Regional	ASEAN (from 1997) – doctors, nurses, dentists
	Micronesia	NO	NA	NA
	New Zealand	NO	NA	NA
	Palau	NO	NA	NA
	Philippines	YES	Regional, Bilateral	ASEAN (MRAs in 2006 and 2009) – doctors, nurses, dentists Japan (2009) – Doctors [training], public health professionals; (2015) – nurses, caregivers Germany (2013) – nurses Canada (2006, 2008, 2010) – all skills Bahrain (2007 – <i>not implemented</i>) – all health professionals Spain (2006) – health professionals UK (2003 – <i>now ceased</i>) – Nurses, other healthcare professionals Norway (2001) – health professionals
	Singapore	NO	NA	NA

Source: WHO Reporting Instrument (2015) reports database, Geneva (http://www.who.int/hrh/migration/code/code_nri/reports), Retrieved 25 July 2017).

International agreements or arrangements were typically Memoranda of Understanding, Agreement or Cooperation. Dates of Bangladesh and Bhutan agreements were not provided. Cambodia described its agreement with Brunei Darussalam as 'regional' but this has been re-coded in the table as 'bilateral' as it involves just the two countries. Japan did not include its bilateral agreements with the Philippines or Indonesia in its NRI return.

ASEAN, Association for South-East Asian Nations; MRAs, Mutual Recognition Agreements; NA, not applicable; WHO, World Health Organization.

development impacts of outward migration. This only holds, however, if decent work/labour standards and specific re-investment provisions are written into the agreements. More often than not, such agreements are devoid of all but the minimum of obligations towards the migrant workers and their country of origin, and have little more than symbolic value (Plotnikova, 2014). The global trade union federation – Public Services International (PSI) – promotes ethical recruitment and rights-based approaches to migration, including in BLAs, under their

Programme on Decent Work and Social Protection for Migrant Workers in the Public Services. PSI, along with other organisations, including the Commission on Health Employment and Economic Growth, point to the good practice in ethical recruitment and human resource development cooperation in the BLA between the Philippines and Germany signed in March 2013. One of the innovations of the BLA is the establishment of a Joint Committee made up of ministries of labour and health and trade unions representatives from Germany and the Philippines. This committee

monitors and evaluates the implementation of the agreement. This innovation is the first of its kind.

Related to this, the 69th World Health Assembly called on member states to develop improved mechanisms for bilateral, multilateral and development partners to work together in assessing health workforce implications assistance programmes. The Commission on Health Employment and Economic Growth (2016) argues that BLAs can strengthen accountability and collaboration between countries, reduce mismatch of supply and demand, take into account the rights of health workers, and promote technical cooperation and investments.

One of the reasons for the increasing use of BLAs is that they offer flexibility: they are easier to negotiate and quicker to conclude, they offer governments more control and regulatory discretion. The balance of power between negotiating parties is a consideration; the stronger party can exercise power over its negotiating counterpart, and by entering into an agreement with just one other government, governments can bypass multi-state political blocs and alliances that emerge in multilateral negotiations. BLAs have the potential to raise social and labour standards much more rapidly as the two negotiating parties can go further in their agreement than is possible in multilateral agreements (Yeates *et al.*, 2010; Plotnikova, 2014). However, bilateralism tends to produce a patchwork of untransparent, variable, fragmented and complex arrangements as they are by definition negotiated one at a time. Also, in some cases they discriminate between nationals, occupational groups and signatory countries.

In order to examine the use and content of BLAs on health worker migration in the Asia Pacific, we analysed the Reporting Instrument reports database of the WHO. This database contains the self-assessment returns ('National Reporting Instrument' (NRI)) submitted by countries as part of their obligations to report every three years on progress in implementing the WHO Global Code, including arrangements that take account of the needs of developing countries and economies in transition. NRIs were introduced in Second Round reporting (2015–2016) to monitor progress in implementing the Global Code,⁹ and the most recent data available is from 2015. From the

perspective of this paper, the NRIs are a useful source of data; our use of them as a source of evidence presents no ethical issues as they are a freely available (and under-used) data resource.

Of the 193 signatories to the Code, 74 returned a NRI; 18 signatories were in the Asia Pacific, accounting for one-quarter of all returns. Table 1 provides a summary overview of these Asia Pacific countries, and shows whether they had entered into a bilateral (or regional) agreement. It provides summary details of the types of international measures that countries had undertaken, the country or countries with which they had partnered, together with the date and occupational category or categories covered by the measures.

As Table 1 shows, about half of the countries (8 out of 18) have entered into an international agreement or arrangement of some kind and have at least one 'live' measure in place, predominantly BLAs. Just two countries (Philippines, Malaysia) report they are party to a regional multilateral agreement (in this case ASEAN) covering the migration of health professionals.

A major determinant of the distribution of risks, costs and benefits arising from international health worker migration is the terms on which international agreements are entered into and who the participating states are. BLAs actively channel health workers labour to overseas markets whether intra-regionally or extra-regionally. Agreements concluded with other similarly situated countries within the Asia Pacific region will likely be less lucrative to the source country than those it concludes with wealthier countries, whether within or outside of the region. Of all these countries, the Philippines stands out as a serial signatory of international agreements, with a long history dating back some two decades and several such agreements signed with countries in Western Europe, North America and the Middle East, as well as within the region (Japan). Notably, lower-middle income countries entered into agreements predominantly with other lower-income countries within the region. Only the Philippines and Indonesia were servicing high-income Japan; Sri Lanka and Bangladesh were servicing an Asia Pacific upper-middle income country (Maldives) (Table 1).

As noted earlier, the extent to which BLAs protect labour rights and mitigate the negative impacts of outward migration depends on the content of the agreement. Certainly, there are examples of 'best practice' in the region. Among the most successful agreements are those which have the principle of equality of treatment embedded in them and which are benchmarked against international labour standards, as is the case of BLAs between the Philippines and Spain and Germany guaranteeing migrant health workers the same rights as Spanish and German workers. A further good practice in using ILO Decent Work standards and ethical recruitment principles can be seen in a Memorandum of Agreement between the Philippines and Bahrain on Health Services Cooperation (Republic of the Philippines and Kingdom of Bahrain, 2007) which is embedded in a framework of equal treatment on the basis that 'Human resources for health recruited from the Philippines shall enjoy the same rights and responsibilities as provided for by relevant ILO conventions.' The agreement covers the exchange of health workers in recruitment, rights of workers, capacity building, sustainability of the development of health workers, and MRAs on qualifications. An ethical framework for the recruitment of health workers was established through a partnership between Philippine and Bahraini healthcare and educational institutions, designed to enhance international education and professional development, and includes scholarships, academic cooperation on health work and technology cooperation. The agreement also specifies the reintegration of health workers who return to their home country. The quality of this Memorandum of Agreement reflects the fact that the Philippines had ratified ILO C97 and C143 and other core conventions, which was not the case with Bahrain. Unfortunately, this agreement has never been implemented, as reported by the Filipino government in its NRI 2015 return (Table 1).

Not all BLAs in the Asia Pacific incorporate such principles. BLAs signed on the basis of economic partnerships have been among the less successful and most exploitative. The bilateral Economic Partnership Agreement signed between Japan and Indonesia (2008), for a quota of nurses and nurse specialists from Indonesia to work in Japan, is an example of this.

Requirements were put in place for Indonesian nurses to take Japanese language lessons and during this time to work as caregivers or assistant nurses at hospitals or nursing homes for the elderly. A similar agreement, the Japan–Philippines Economic Partnership Agreement, led to nurses returning to the Philippines with complaints from nurses about exploitative employment practices, poor support and lack of facilities for integration (Pillinger, 2013; Yagi *et al.*, 2014).

One problem with BLAs is their increased usage is associated with a policy shift towards temporary and circular migration. Circular labour migration is actively promoted by many high-income destination countries. Supported by the IOM, the European Commission and individual European countries, BLAs regularly surface in policy forums as a solution to a country's development needs and as an alternative to permanent migration. The Global Forum on Migration and Development, for example, highlights that 'bilateral or circular labour agreements, including MRAs ... are expedient, more targeted, mutually agreeable, and cost effective' (GFMD, 2012). Circular migration is seen as conducive to facilitating 'brain gain' and 'brain circulation', so that specialist knowledge and experience gained from working overseas can be used as a tool for development and contribute to quality health services when the individual migrant returns home after their timebound right to reside overseas expires (GFMD, 2013).

Despite the growth of BLAs promoting circular migration, there is no evidence that it is preferred by skilled health workers or employers, or that it fosters migration of the kind involving continued connection with, and integration in, source and destination countries (Newland, 2009). Indeed, temporary and circular migration may restrict migration choices and the right to enjoy permanent patterns of migration (Wickramasekara, 2011). Global trade unions (PSI, 2010; ITUC, 2011) have been critical of temporary and circular migration programmes as they can exacerbate precarious and exploitative work and diminish workers' rights to training, career development, decent work standards and family reunification. Circular and temporary labour programmes are *only* sustainable if they promote the development of skills and human resources necessary to strengthen public service delivery in both source

Table 2. Types of measures that take account of the needs of developing countries and countries with economies in transition

	Training	Twinning of health facilities	Promotion of circular migration	Retention strategies	Educational programmes	Other
Bangladesh	X	X			X	
Bhutan	No measures taken					
Indonesia	X			X		
Maldives	No measures taken					
Myanmar	X				X	
Cambodia	X		X			
Malaysia	X					
Philippines	X	X	X		X	Investment to improve health facilities

Source: World Health Organization Reporting Instrument (2015) reports database, Geneva (http://www.who.int/hrh/migration/code/code_nri/reports, Retrieved 25 July 2017).

This data is based on self-reporting by governments having entered into an international agreement on health worker migration. Bhutan and Maldives both report that the bilateral agreements into which they have entered (see Table 1) do not take account of the needs of developing countries/economies in transition.

and destination countries, *and* facilitate knowledge transfer and 'brain gain' in low income countries (PSI, 2010).

International agreements that meet these conditions are few and far between. The absence of in-built mechanisms to build the capacity of health workers and the health sector by, for example, reducing outflows of health workers from rural areas, reducing attrition and introducing incentives and policies to retain highly skilled workers, and putting in place policies for 'brain gain' and knowledge transfer, as well as research and training between source and destination countries, means the potential of bilateral labour or trade agreements to contribute to economic and social development remain unrealised (PSI, 2010). Indeed, our analysis of Asia Pacific countries' NRIs shows the variable quality of BLAs covering health workers in the region. Table 2 summarises the different types of measures in place that take account of the needs of developing countries (and economies in transition), as reported by the seven Asia Pacific governments that have entered into a BLA. The most common among these measures are training and educational programmes, followed by measures for the twinning of health facilities and for promoting circular migration. No government reports that equality of treatment or decent work standards are a feature of their international agreements. Notably, two countries (Bhutan and Maldives) state that their agreements do not take account of the needs of developing countries or economies in transition.

It is difficult to interpret this statement. However, of note is that those two countries are among the most active in forging agreements, be it with other lower middle income Asia Pacific countries or with higher income ones within the region and beyond (Japan, Cuba) (see Table 1).

Discussion and conclusions

Recent decades have seen health workforces become deeply embroiled in processes of global and regional economic restructuring, the remaking of political action and cooperation across broader integrative scales, and greater degrees of inter-connection and inter-dependence between populations, social systems and countries around the world, such that policies implemented in or by one country or region can have significant enabling or destabilising effects elsewhere. The international policy universe on health worker migration that we focus on in this paper has become prominent in the Asia Pacific as elsewhere because of the concern about the destabilising effects of such migration on countries' resourcing and management of their health services and on population health. Migration is a significant feature of health workforces in the region and this paper has brought new evidence and fresh insights to bear on the transnational dynamics of these. It shows that the migration of health workers and the governance thereof needs to be understood in regional and global terms as well as in

national terms. Intra-regional health worker migration (from poorer to richer Asia Pacific countries) accompanies emigration to richer zones of the world economy outside the region. This migration is associated with poor health resourcing and poor health outcomes. However, it is not the root cause of such problems. It is one factor in a wider mix of factors conditioning whether health services are available, accessible and suitable to meet the health needs of the population.

The international institutional and policy frameworks analysed in this paper have emerged in a regional context of variegated patterns of development (and under-development), polarised inter-state inequalities, and divergent institutional regimes of health resourcing, health worker education and training, and health workforce management. Thus, abutting the wealth of Australia, New Zealand and Japan, the region contains many of the countries with the world's poorest populations. Located predominantly in Southeast Asia, these have the world's highest disease burden, the greatest shortfall of health workers, and their health outcomes are among the worst in the world. This divergence generates testing challenges for international policy initiatives when it comes to addressing health worker migration and the Global Goal of providing universal healthcare leading to improved health outcomes across the Asia Pacific.

These questions were 'set out' in the abstract: important questions of what international policy initiatives and responses are at work in the Asia Pacific region, and what these mean for the nature of migration governance in the region. We consider in particular how a focus on transnational policy can help with attaining universal healthcare and improved health outcomes in the region.

This paper has demonstrated how multiple international policy initiatives, responses and interventions on international health worker migration are taking place in the Asia Pacific. The principal multilateral policy frameworks are the Global Code and the ASEAN health labour migration initiatives, while strategies emanating from the UN High-Level Commission on Health Employment and Economic Growth (2016) are likely to become important. BLAs covering multiple health professionals have been instituted

by seven countries in Southeast Asia where health worker shortages are most critical. The Philippines stands out as a serial signatory of international agreements, with commitments through bilateral, regional and global instruments. Collectively, these international agreements and accompanying programmes of action cover key issues of ethical recruitment, 'circular' migration and labour rights, and key themes of health workforce planning and management.

Our focus on a broad array of international policy initiatives and institutions expands the analytical focus of the existing international literature from the Global Code and its impacts on national policy to clearly focus attention on the *multiplicity* of border-spanning institutions, initiatives and actors in this field and of the *multi-sectoral* nature of health workforce governance. Multilateral and bilateral modes of governance are co-present and co-operate within the same policy 'space'. They are enacted through an array of treaties, agreements, codes, projects and programmes of action that intersect the region, forging strategic alliances and partnerships of different kinds. Not all of these modes of governance originate from a specific concern to address health workforce and health outcomes issues, but many of them do. Where the originating concern lies elsewhere (e.g. with security, trade or economic development) measures have been instituted to bring a focus on these issues (ASEAN and WB are cases in point).

The international agreements that Asia Pacific states are signing up to cannot be separated from the multi-faceted inequalities that characterise the region or the wider issues of migration governance. These inequalities begin with the outcomes of past 'development' that position states differentially in global and regional hierarchies; they manifest in poorer countries servicing richer ones with significant health resources (skilled health professionals), and are institutionalised through the conclusion of inter-state agreements that facilitate health worker migration (whether through mutual recognition arrangements or fast-track visas and placement of migrants) but do not ensure compensating development returns to the sending countries. This is a clear failure of the global policy principle of shared responsibility for pursuing development strategies that aim for the highest social

standards. The agreements that have been instituted through multilateral and bilateral initiatives are supportive of temporary and circular migration 'solutions' to chronic problems of under-resourced health services and labour forces. Although they are underpinned by a human right to migrate, this right is not supported by corresponding rights to decent working conditions and social protection equal to those enjoyed by nationals of the countries to which the health workers migrate. Only very few BLAs approximate good practice, one of which (the Filipino-Bahraini agreement) was never implemented. Neither the Global Code nor international norms on social protection and labour standards (which are applicable to migration governance) have so far provided enough countervailing weight to significantly influence the design of regional agreements or to condition their implementation.

In general terms the initiatives reflect the consensus that health worker migration is a global issue requiring a comprehensive multi-level set of responses. Yet while the need for coordinated and integrated responses at global, regional, national and sub-national levels is well understood, there seems to be far less progress in instituting such responses. The governance of international health worker migration in the Asia Pacific is less a coherent, unified affair than a pluralistic amalgam of institutions, actors, agencies, policies and initiatives all contributing to complex process of influence, decision-making and administration. Under these conditions regional and bilateral policy initiatives are in effect postponing comprehensive, coordinated and integrated responses that are so urgently required to attain international standards of social protection, universal health care and improved health outcomes across the region.

These are significant issues with which the High Commission will need to seriously engage with if it is to make substantial progress towards the universal healthcare ambitions that fall within its remit. The impetus and opportunities afforded by the multi-partner platform to deliver the right number of jobs, the right skills, in the right place at the right time must be seized. As a starting point, the platform partners need to ensure that the strategy to increase the number of jobs in the health sector is in practice firmly underpinned by decent working conditions and social

protection principles. In this, the High Commission's initial statement of commitment to these principles must be translated into practice at all stages and levels. 'High road' strategies in the healthcare sector need to involve appropriate regulatory control, adequate public funding and strategies that build on the common interests of healthcare workers and users. These are essential ingredients to recruitment, retention and deployment, as well as to high quality outcomes from employment investment. Following the regional focus of this paper, regional platforms are needed and should include all major stakeholders in the region, so that contextualised regionwide strategies and programmes of action can be developed. Regional 'road maps', akin to those developed by the UN Regional Economic and Social Commission for the Asia Pacific in relation to the Sustainable Development Goals (UNESCAP, 2017), would help crystallise the region-specific issues, identify common approaches and flexible response sets, and mobilise all partners in the support of attaining the goal of providing high quality universal healthcare services (Yeates, 2017). Such regional platforms, and the road maps that follow from them, could usefully give contextualised specificity to the thematic priorities identified by Campbell *et al.* (2013). They would also give clear regional expression to the principles of shared responsibility for and multi-stakeholder ownership of the Global Goals.

Ongoing efforts to build coordinated public policies across migration, health and social protection, and to strengthen global and regional alliances and networks are urgently needed. These need to be capable of campaigning for and delivering effective policy strategies to eliminate health worker shortages and ensure more adaptive responses to health worker migration. These strategies need to be underpinned by firm commitments to human rights and comprehensive labour and social protection. To this end further research and contextualised analysis of the transnational dimensions of policy are needed to keep in clear sight the specificities of country and regional contexts. In addition, insightful observation of the interplay between transnational and national actors, institutions and policies across different but complementary spheres of governance in the shaping of health workforces, health worker migration,

health resourcing and health outcomes is required. This insight will help to consolidate the range of policy actors, from within the region and outwith, engaged in debate as to the most effective ways of producing and managing health workforces capable of delivering high-quality health services, and enable them to devise more effective, integrated and coordinated 'multi-level' strategies and policy responses in the region.

Notes

- 1 The Asia Pacific region encompasses countries of South-east Asia, East Asia, Polynesia, Australia, Aotearoa New Zealand, Melanesia, Micronesia and South Asia. The Association of Southeast Asian Nations (ASEAN) includes Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam. Papua New Guinea has observer status but is not a member.
- 2 The WHO threshold is 22.8 skilled health workers per 10 000 population.
- 3 For example, this is the case for Australia, a major recruiting country where permanent inward migration of overseas registered nurses has increased sixfold since 1990 (Pillinger, 2012), and for the Philippines, a major health worker 'donor' country internationally, where there are an estimated 200 000 unemployed and under-employed nurses (Lorenzo et al., 2007; Pillinger, 2013).
- 4 Yeates (2009) (drawing on Tyner 1999) identifies the Philippines, Indonesia, Sri Lanka as examples of countries with 'mature' health worker export strategies, and Bangladesh, Korea, India, Indonesia and Vietnam as more recent Asian examples.
- 5 We acknowledge the comments of an anonymous reviewer in drawing this to our attention.
- 6 MRA on Nursing Services, 2006; MRA on Medical Practitioners and MRA on Dental Practitioners, both 2009. (ASEAN, n.d.).
- 7 Practice requirements differ even at the level of countries. With regard to physicians there have been recent attempts to unify the medical curriculum and the examination systems across Indian states, and to unify medical licensing within the United Arab Emirates (Kittrakulrat et al., 2014).
- 8 The scale of the anticipated labour shortages due to the ageing of the workforce, the growth of demand, rising healthcare costs and difficulties in recruiting new students into the health sector is significant (Commission on Health, Employment and Economic Growth, 2016). In the USA, significant shortfalls of health professionals in primary care are predicted for 2025 (U.S. Department of Health and Human Services, 2016), while in relation to nursing some US states have an over-supply and others an under-supply of nurses (U.S. Department of Health and Human Services, 2017). Shortages of 500 000 nurses and of 44 000 family physicians are forecast in 2025 (American Association of Colleges of Nursing, 2013). Shortages across all EU countries will be

close to 2 000 000 by 2020 (European Commission, 2012). Projections are that the domestic supply of physicians in Japan will not overcome estimated deficits until 2036 (Ishikawa et al., 2013), while Health Workforce Australia (2012) anticipates a reduced supply of up to 109 000 nurses by 2025. Furthermore, countries with lower income levels are recruiting overseas – including regional hegemony Brazil and South Africa, and Saudi Arabia.

- 9 The NRI sought information from governments about national measures to support Code-consistent responsibilities, rights and recruitment practices; health workforce development and health system sustainability; partnerships, technical collaboration and financial support; and data gathering, research and exchange.

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